the AFIP
LETTER

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Armed Forces Institute of Pathology
Washington, D.C. 20306-6000

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Strategic Planning: AFIP in the 21st century

What will the AFIP of the 21st century look like? What will the Institute's role be in military and civilian medicine? Who will be our stakeholders and how will our services impact them? These are but a few of the many questions being asked as the Institute embarks on a comprehensive strategic planning process, according to AFIP Director Michael J. Dickerson, Col, USAF, MC. "We want to maintain and enhance our support of both military medical readiness and the global healthcare community by providing distinctive and preeminently excellent services in pathology consultation, education, and research," he says.

AFIP's strategic planning process began in 1995, when Colonel Dickerson encouraged AFIP staff to focus on a vision and mission for the Institute and to develop a validated strategic plan. "The strategic plan needed to be a blueprint for what we did and how we did it, with the overall premise that we would provide quality services—worldwide—to our stakeholders and customers," he says. "The motto (borrowed from the Navy) became 'the right people, with the right training, for the right reasons, in the right place, at the right time.'" Colonel Dickerson appointed AFIP Deputy Director Glenn N. Wagner, CAPT, MC, USN, to oversee the planning process. "Captain Wagner is the perfect choice to facilitate this process. His knowledge of the Institute, its staff, and programs is exceptional."

Colonel Dickerson reviews key strategic planning issues with Executive Committee members (from left) COL James Durham, Dr. Florabel G. Mullick, and CAPT Glenn Wagner.

To develop its strategic plan, the Institute contracted with Executive Forum of Colorado, Inc., a Denver-based human resources and consulting firm that specializes in training design, productivity improvement, leadership development, and creating employee commitment. Executive Forum is headed by Marjorie Mauldin, an organization design and development expert. Ms. Mauldin has 15 years' experience in organizational development with Federal agencies and national and international companies; her clients include the U.S. Department of Energy and Department of the Interior, Lockheed Martin, and Ball Corporation. Working with her is "futurist" Michael Annison, president of the Westrend Group and author of the award-winning book *Managing the Whirlwind: Patterns and Opportunities in a Changing World*. Mr. Annison has extensive experience in the healthcare management field.

In November 1995, Ms. Mauldin and Mr. Annison began an extensive series of interviews with Institute personnel, including the executive committee, department chairpersons, and working groups made up of employees eager to participate in the process and take the opportunity to "write their own future."

The interviews led to an offsite retreat, held in Gettysburg, Pa., from May 5-7, 1996. The retreat, according to CAPT Wagner, had "as broad an AFIP representation as 30 people could pro-

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DIRECTOR'S MESSAGE

Keeping our customers first

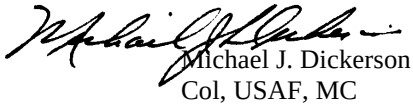
AFIP's customers - the Department of Defense (DoD) and the international medical community - are our top priority.

That's what our internal strategic planning process is all about - serving you better. We're looking at ways to provide you with continued quality services into the 21st century.

We've established a number of internal "teams" to evaluate four major issues identified at our May retreat: our mission and vision; DoD relevance and operational expectations; collaborations; and internal operations. The next phase of the plan will take place in August, when we'll take our findings to an external body of stakeholders for their input. They include representatives from our Board of Governors, Scientific Advisory Board, and American Registry of Pathology Board. They'll be providing us with advice and guidance for how our proposed plan will impact the perceptions and expectations of our customers.

We're working diligently to complete the plan by early October, when our Board of Governors will meet to formally review it. This is by no means a simple process. We are challenging our staff to share ideas for improving the AFIP, and to deal with change constructively. Critical issues, from what our priorities should be to how to manage them, are now "on the table." The outcome will be a comprehensive plan that will strengthen the Institute's capabilities in the years ahead.

As always I welcome your comments or observations about the AFIP. Send them to: The Director, AFIP-ZA, Washington, DC 20306-6000. Internet: <Dickerso@email.afip.osd.mil>



Michael J. Dickerson
Col, USAF, MC
The Director

CD-ROM Update

CD-ROM SALES OF THE FIRST 12 AFIP Atlas of Tumor Pathology Series III fascicles are encouraging, according to Jonathan Johnstone, director of marketing for the American Registry of Pathology (ARP). "Over 800 have been purchased since the end of March," he notes, "and we are impressed by the number of AFIP Atlas Subscribers that have added the CD-ROM to their fascicle subscription." Initial user feedback has been favorable, as many pathologists are pleased with the format and quality of the images. "We expect to publish *Tumors of the Lower Respiratory Tract* on CD-ROM sometime this fall," Johnstone says, "and it will be the first to contain 383 additional color illustrations and 172 color illustrations replacing original black-and-white figures."

Fascicle News

The next fascicle due to be published is *Tumors of the Esophagus and Stomach*, set for fall 1996. The AFIP Atlas Subscribers Program continues to grow. Over 5,000 pathologists are a part of the Subscribers Program, automatically receiving each new fascicle at discounted rates. Approximately 2,000 books are also sent to 6 international distributors in Japan, Germany, Italy, Spain, and the United States (for service to foreign libraries). These distributors have their own subscribers to the fascicles. For more information about the Subscribers Program contact Michael Tabash at 202-782-0370. FAX 202-782-0941.

AFIP/ARP at future pathology meetings

AFIP and ARP will staff a joint exhibit at the fall 1996 meeting of the American Society of Clinical Pathologists/College of American Pathologists (ASCP/CAP) in San Diego, Calif., September 30 to October 2. ARP will also exhibit at the Royal College of Physicians and Surgeons meeting, Halifax, Nova Scotia, September 26-28; at the Frankfurt Bookfair, Frankfurt, Germany, October 2-7; and at the International Congress of the International Academy of Pathology (IAP), Budapest, Hungary, October 20-27.

EDUCATION SPOTLIGHT

Difficult Diagnoses in Surgical Pathology set for Charleston, South Carolina, November 13-16, 1996

The Old Exchange and Provost Dungeon. Courtesy of the Charleston Area Convention & Visitors Bureau

AFIP returns to Charleston, South Carolina, from November 13-16 for the second annual "Difficult Diagnoses in Surgical Pathology" course, according to course codirectors Cesar A. Moran, Maj, USAF, MC, chief, Mediastinal Pathology, Department of Pulmonary and Mediastinal Pathology, and Bruce M. Wenig, MD, assistant chair, Department of Otolaryngic and Endocrine Pathology and chief, Otolaryngic Division. This year's course will be held at the Charleston Place. "We are returning to a beautiful city, one that is rich in history, culture, and architecture," notes Major Moran. Over 150 registrants participated in the 1995 course, and a similar number are expected this year.

This course is designed to cover a wide variety of diagnostically challenging entities that present diagnostic dilemmas, and a detailed syllabus will be provided. "Following registration, a set of 11 cases with clinical histories will be mailed to each registrant, and it will be theirs to keep," says Dr. Wenig. A key listing the diagnosis for each case will be provided at the end of the course.

The course will emphasize differential diagnoses and the utilization of special techniques (immunohistochemistry and molecular biology) in the diagnosis process. Recent advances in therapy and prognosis will be discussed, and case presentations will be based on the slides distributed to course attendees. The course is designed to be of interest for the practicing surgical pathologist, pathology residents, and clinicians.

In addition to noted AFIP staff members, the faculty includes guest speakers who through the years have provided information in peer-reviewed journals and will provide cases of their own to review. They are **Christopher D.M. Fletcher**, MD, MRCPath, professor of pathology and director, Surgical Pathology, Brigham and Women's Hospital, Harvard Medical School, Boston, Mass.; **Hideko Kamino**, director, Dermatopathology, New York University Medical Center, New York, NY; and **Saul Suster, MD**, director, Anatomic Pathology, Mount Sinai Medical Center, Miami Beach, Florida.

DEPARTMENT OF REPOSITORY AND RESEARCH SERVICES

Repository expands; visit us on the Web!

The Department of Repository and Research Services is pleased to announce the awarding of a contract for the construction of a 16,000 sq ft addition to our main repository building located at the Forest Glen Annex of Walter Reed Army Medical Center in Silver Spring, Md. Our current warehouse is filled almost to capacity, and this addition will be used to facilitate the growth and expansion of our pathologic materials repository as new materials are received. It will also be used to house the pathologic materials from closed military medical facilities that the AFIP is currently storing at our Gaithersburg warehouse. Construction will begin sometime in September 1996, with a tentative construction completion date of December 1997.

The Department of Repository and Research Services is also pleased to announce that we now have a home page that can be accessed through the AFIP home page - **http://www.afip.mil**. The department's home page contains valuable information on sending cases to the Institute, requesting the return or loan of case material, and opportunities for collaborative research. Comments or suggestions for improvement can be sent via e-mail to anderson@email.afip.osd.mil or peterson@email.afip.osd.mil, or mailed to our department at 6825 16th Street, NW, Washington, D.C. 20306-6000.

PROFILE

Paul E. Bluteau, COL, MS, USA, appointed AFIP Executive Officer

PAUL E. BLUTEAU, COL, MS, USA, has been appointed as the AFIP's new Executive Officer. In his new role, COL Bluteau will oversee the Institute's administrative services, including logistics, resources management, personnel, information management, public affairs, and safety. He comes to AFIP from Medical Center Brigade, Walter Reed Army Medical Center, where he served as the Medical Center Brigade Commander.

Born in Colorado but raised in upstate New York, COL Bluteau received a BS degree in physical education from Norwich University, and earned a master of arts degree in institutional management from Webster University in 1981. He entered active duty as a Medical Service Corps officer from Norwich University as a Distinguished Military Graduate in 1972.

Upon completion of the Officer Basic and Patient Administration courses, he assumed command of E Company, 3D Battalion, at the U.S. Army Medical Training Center at Fort Sam Houston, Texas. Following his command, he assumed duties as the Administrative/ Executive Officer of the 665th Dental Detachment in Taegu, Korea. Upon his return from Korea, he was assigned to the 24th Infantry Division, where he served first as Commander of HQs and Support Co. of the 24th Medical Battalion and subsequently as the Operations, Intelligence and Training Officer of the same battalion. He returned to Fort Sam Houston, Texas, for the Officer Advanced Course and continued there as an instructor in the Field Medical Support Branch, and then as the Chief of Operations within the Military Science Division, Academy of Health Sciences.

After completion of Command and General Staff College, he served as Medical Readiness Manager in the Medical Wartime Hospital Integration Office, Office of the Surgeon General, U.S. Air Force, at Fort Detrick, Maryland. Following an assignment as operations officer in the Deployable Medical System Project Management Office, he was reassigned as the U.S. Southern Command desk officer, Directorate of Health Care Operations, Office of the Surgeon General, Department of the Army staff.

He was then selected and assumed command of the 210th Forward Support Battalion, 10th Mountain Division (Light Infantry) at Fort Drum, New York. Following his successful command, he attended the U.S. Army War College at Carlisle Barracks, Pennsylvania. After graduation from the War College, he was assigned as the Deputy Chief of Staff, Walter Reed Army Medical Center, and his most recent assignment as the Center Brigade Commander.

MUSEUM

Changing exhibit set to open

Physical training injuries highlighted in first display

An exhibit highlighting current news topics and recent research findings will open in late July at the National Museum of Health and Medicine. Related to the "Human Body/Human Being" display, which includes nine exhibits designed to illustrate and explain human biology, the new display will highlight a single topic. The opening theme will focus on recent research in the causes, prevention, and treatment of lower limb injuries in women engaged in intense physical training. "This will be a changing exhibit," notes Museum Director Adrianne Noe, PhD, "and it will be updated approximately three times a year with a completely new theme. We'll have 'In the News' displays to highlight current news topics, and research findings will be featured in displays tentatively titled 'Research Matters.'"

According to Tony Falsetti, PhD, a physical anthropologist on the Museum staff who researched injuries sustained by women in intense physical training, the exhibit features the research background (rates of injury) as well as current research on military recruits and civilian competitive athletes. "Skeletal differences in males and females, which are thought to contribute to traumatic, overuse, and stress injuries, are illustrated with photographs and displays of pelvic, thigh, and leg bones from human skeletons," he points out. The display also includes information on training techniques designed to help prevent such injuries.

"Statistics on injury rates in Army basic training show that more female recruits suffer lower limb injuries (such as knee strains, shin splints, and plantar fasciitis) than do male recruits," Falsetti says. By examining skeletal bones, he discovered that, in addition to greater hip width, adult women generally have a smaller "notch" in the end of the femur, which may increase their chances of damaging a knee ligament while engaged in strenuous activity. His research was the basis for the new exhibit, designed by Museum exhibit specialist Sarah Carey.

Camala Cline, Capt, USAF, BSC, Altitude and Hyperbaric Physiology Division, Department of Scientific Laboratories, AFIP, who holds a PhD in exercise physiology, worked with Dr. Falsetti to develop training techniques to help reduce the incidence of this type of injury in susceptible individuals. These techniques are illustrated and explained in the exhibit.

PROFILE

Fathollah K. Mostofi, MD, honored for 50 years of government service

AFIP's Fathollah K. Mostofi, MD, chair of the Department of Genitourinary Pathology and the world's foremost authority on the subject, was honored for 50 years of government service on May 23, in a special ceremony prior to the Ash Lecture.

A native of Tehran, Iran, Dr. Mostofi came to the United States in 1931, earned his bachelor's degree from the University of Nebraska, and received his MD degree from Harvard University. Following internship and residency training programs, he entered the U.S. Army in 1944. In 1947, following his discharge from the Army, he completed a fellowship at the National Cancer Institute, National Institutes of Health. In 1948, he was hired as chair of AFIP's Department of Genitourinary Pathology.

During his tenure at the Institute, Dr. Mostofi has served as scientific director, American Registry of Pathology, and as chair, Center for Advanced Pathology and associate director for consultation. Dr. Mostofi is extremely active in international activities, serving as advisor or consultant to the World Health Organization, the International Agency for Cancer Research, the International Union Against Cancer, NATO, and the Pan American Health Organization. He has been the recipient of numerous prestigious awards, including the Distinguished Executive Rank Award presented by President Reagan in 1982.

"We are proud tonight to pay him homage and honor, not just for what he is and has been for the AFIP, but for what he's been for medicine in general, pathology in particular, and urology," said AFIP Director Michael J. Dickerson, Col, USAF, MC, during his introductory remarks. Col Dickerson presented Dr. Mostofi with a certificate for 50 years of service to the Government of the United States and the Meritorious Civilian Service Award for his dedication and expertise as chair of the department.

Col Dickerson also presented Dr. Mostofi with a framed letter from President Clinton in honor of the occasion. "I am delighted to commend you as you celebrate fifty years of dedicated medical service," wrote the president. "Your efforts have saved lives and brought comfort to many, and your steadfast devotion has earned you the trust and respect of your colleagues and patients. On behalf of all those who have benefited from your service, I thank you for a job well done."

Helping to honor F. K. Mostofi, MD, (center) were Major General Ronald R. Blanck, USA, Commander, Walter Reed Army Medical Center (left), and James A. Zimble, MD, President of the Uniformed Services University of the Health Sciences.

Joining Dr. Mostofi on the stage were Florabel G. Mullick, MD, SES, AFIP Associate Director and Director, Center for Advanced Pathology, and Donald W. King, MD, Executive Director, American Registry of Pathology. "He has been a teacher and a mentor and a friend to many," said Dr. Mullick, "but what he is and will continue to be is the best ambassador the AFIP will have." Dr. King presented a letter of congratulations and thanks from the dean of Harvard Medical School for his outstanding financial support over the years, and then presented Dr. Mostofi with a Harvard bow tie to add to his collection. A surprise visit from COL John McLeod, chief of Urology Service at Walter Reed Army Medical Center, concluded the presentations. COL McLeod read a letter of thanks from Senator Richard Shelby (R-Ala), who personally benefited from Dr. Mostofi's expertise.

"I'm very much touched by what has happened tonight," began Dr. Mostofi in his remarks. "Colonel Ash invited me to join the staff in 1946, and I have worked under 14 directors. I've been extremely fortunate to have people who have been with me for many years, including technologists and secretaries." Dr. Mostofi paid special tribute to two current staff members, Dr. Charles Davis and Dr. Isabel Sesterhenn, and one former staff member, Dr. Tatiana Antonovych, for their support and dedication. "Through these years the staff of the AFIP at all levels have been most helpful and have done everything to satisfy my demands, and sometimes my demands can be quite unusual! I do want to express my deep appreciation for the honor that you have bestowed upon me," he concluded to a standing ovation.

ARP:
ITS HISTORY & FUTURE

The American Registry of Pathology: decades of service to the AFIP and civilian medicine

ARP Past Presidents and Executive Officers, AFIP, June 1995. Front row: the late K. Earle, F. Townsend, Mrs. R. Palmer, J. Humes. Back Row: J. Layton, E. Cowart, W. Dolan, R. Stowell, T. C. Jones, J. Kleinerman, D. W. King.

Here is a brief review of ARP's history and plans for the future

1921-1975

In 1921, a group of members in the ophthalmology and otolaryngology societies located at the Army Medical Museum joined to form a combined registry to provide an archive for rare tumors. Other specialty societies followed this example and sponsored separate registries at the AFIP. In 1939, they were organized into a formal section of the Institute known as the American Registry of Pathology(ARP).

The registries and their sponsoring societies assembled teaching sets of glass slides (37,000 microscopic slides in 25 sets) that were sent free of charge to pathologists throughout the world for study. The registries also accepted specific slide collections to archive and study, a practice that continues today.

In 1950 the Subcommittee on Oncology of the Committee of Pathology of the National Research Council (NRC) published the *Atlas of Tumor Pathology* fascicles (Series I). In 1964, a group of academic chairmen founded the Universities Associated for Research and Education in Pathology (UAREP), which assumed the responsibilities of the NRC. UAREP acted as the cosponsor of the *Atlas of Tumor Pathology* and sponsor of many grants and contracts for the AFIP/ ARP.

1976-1989

In 1975, disagreement existed in the military regarding AFIP's alliance with the civilian medical community, specifically the ill-defined relationship between the AFIP, ARP, and UAREP. In 1976, legislation introduced by Senators Edward Kennedy (D-Mass) and Sam Nunn (D-Georgia) established the ARP as a 501c(3) Foundation designed solely to help the AFIP with its interactions with U.S. and international medicine.

The resulting Public Law 94-361 formally chartered the ARP to assume fiduciary responsibility for accepting grants and contracts and granted the ARP permission to engage in publication, consultation, and education programs. ARP was specifically empowered to employ six Distinguished Scientists (now raised to an indefinite number) who were permitted to assume supervisory responsibilities with federal employees.

From 1978 to 1990, civilian consultations slowly expanded, research grants increased, contracts evolved, and educational courses increased. Between 1967 and 1991, 28 fascicles in Series II were published, with an editorial board selected by AFIP, UAREP, and ARP representing the foremost surgical pathologists in the country. ARP continued to interface with civilian medicine, establishing collaborative research programs and mutually beneficial educational endeavors.

1990-1996

From 1990 to 1996, ARP embarked on a series of new endeavors. It accepted responsibility for publishing, marketing, and distributing fascicles and received the sales revenues formerly returned to the U.S. Treasury. Sixteen Series III fascicles were printed between 1991 and 1996, with sales increasing from 16,000 to 50,000 copies per year. Electronic versions of the fascicles (on CD-ROM) were introduced, and plans are in progress for a new nontumor fascicle series.

ARP developed a strong infrastructure in support of the AFIP, particularly in consultation and education. With the approval of the Army Judge Advocate General (JAG) Office, ARP instituted fees for civilian consultation services. Presently, there are approximately 20,000 fee-paid civilian consultations received each year. ARP also instituted free Federal Express service for contributors, provides a toll-free number for inquiries, and coordinates the faxing of all diagnoses on the date of completion.

ARP provides extensive support for AFIP educational programs, encouraging nationwide expansion of courses, developing more complete brochures, and providing fiscal services for reimbursement of faculty, travel, and other expenses. ARP contributes to AFIP's Home Page on the World Wide Web, and expended over $200,000 for course support and equipment to the Telepathology Program, including establishing three peripheral

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American Registry of Pathology marks 20th anniversary of its charter

Thomas E. Mann, PhD, was the featured speaker at the ARP dinner.

The American Registry of Pathology (ARP) celebrated the 20th anniversary of its Congressional charter with a series of special programs on May 22-23, 1996. "We wanted to mark this special occasion with a look toward the future," says **ARP Executive Director Donald W. King, MD**. On May 22, over 200 ARP board members, invited ARP and AFIP staff, and other guests took part in a special anniversary dinner at the Cosmos Club in Washington, DC. There, **Thomas E. Mann, PhD**, director of the Governmental Studies Program and the W. Averell Harriman Senior Fellow in American Governance at the Brookings Institution, spoke on "Campaigning and Governing in 1996."

Events on May 23 included a special morning symposium featuring three distinguished speakers. **David Korn, MD**, Distinguished Scholar in Residence at the Association of American Medical Colleges and a former vice president of Stanford University, spoke on "Legislation Related to Genetic Testing and Research." **Edmund D. Pellegrino, MD**, Director of the Center for Clinical Bioethics, Kennedy Institute of Ethics, Georgetown University, spoke on "Making Rounds with Mammon—Academia and Managed Care." **Ralph W. Muller**, President and CEO of the University of Chicago Hospitals and Health System (UCHHS), spoke on "Major Health Care Reorganization."

The afternoon session consisted of a formal ARP Board meeting and focused on the role of AFIP and ARP. Members were addressed by **Michael J. Dickerson, Col, USAF, MC**, AFIP Director; **Donald W. King, MD**, ARP Executive Director; and **Jack Layton, MD**, President of the American Registry of Pathology. A discussion by the Board and registrars followed. The 2-day celebration came to a close following the **12th Annual James Earle Ash Lecture**, delivered that evening by **James A. Zimble, MD**, President of the Uniformed Services University of the Health Sciences. Dr. Zimble spoke on "Walking the Walk—Sustaining the Stewardship of Military Medicine."

***ARP History**, continued from page 6*

sites on military installations.

ARP has expanded its Callender-Binford Fellowships from 2 to 14 per year, provides partial support to over 15 new research projects each year, and has contributed over $135,000 to Museum activities. To improve the intellectual environment of the Institute, it sponsors numerous seminars and lecture series throughout the year. ARP also maintains its ties with the civilian medical community by cosponsoring symposiums for hundreds of medical students and residents from around the country.

ARP contributes heavily to the infrastructure of the Institute, providing direct support to numerous personnel in the consultation, education, publications, and accounting services. New chairpersons are supported with equipment, grants, and fellows, and ARP staff members receive over $500,000 annually in salary contributions.

The Future

Together with AFIP, the American Registry of Pathology is working to increase communication with other military organizations, governmental agencies, and civilian populations from around the world. Every senior military resident and some military staff will spend 1 to 2 months at AFIP, and all civilian senior residents will have an opportunity to visit the AFIP during their training. ARP will expand its economic viability by strengthening its national educational programs, developing a wider, more efficient consultation service, and increasing research capabilities through more specialized grants and contracts in a few focused areas.

ARP now represents almost one-third of the personnel working at AFIP and will continue to be critical in recruitment of chairpersons, distinguished scientists, junior staff, and technical, secretarial, and research staff. It will continue to help the AFIP as the Institute develops its strategic plan, including focused objectives in research, consultation, and educational programs. We are proud to be an integral part of this esteemed organization.

Strategic Planning, *continued from page 1*

vide." For more than 2 days—from breakfast through dinner—participants worked intensively to develop strategic vision and mission statements and to identify critical success factors for the AFIP and its future roles. Executive Forum personnel acted as moderators, introducing discussion topics, ensuring that dialogue remained relevant to the topic at hand, and recording and analyzing information from the sessions.

Key issues identified by retreat participants included four critical success factors: (1) aggressive support for the Department of Defense (DoD), emphasizing readiness and mobilization issues; (2) developing more effective working relationships with health care providers to improve patient care and influence policy; (3) simplifying and improving operations to enhance the quality of our services using fewer resources; and (4) recognizing the currency of our expertise through the reputation and capabilities of our senior staff. Pathology consultation, education, and research were recognized as critical tools for accomplishing the mission, rather than the mission itself.

The next step in the strategic planning process was assembling "process action teams" of Institute personnel to analyze the current activities and collaborative relationships, forecast future needs, and develop an aggressive, relevant infrastructure to support the strategic mission. "The goal is to expand the Institute's resulting capabilities by exploiting advances in technology, epidemiology, medical intelligence, public health, and preventive medicine, linking the core basic sciences with the clinical sciences, based on future health care needs and the role of pathology in this endeavor," says CAPT Wagner.

In the next few months, the process action teams will evaluate major areas such as clinical priorities, collaborations, clients, customers, constituents, DoD expectations and relevance, managing priorities, quality improvement and re-engineering, leadership, and financial soundness. Smaller "subissue" process action teams (PATs) were formed to address issues identified by the primary PATs. Based on current measurements and projections, these teams began performing in-depth analyses of current and projected stakeholders and customers to determine the services and structure that might be needed. "The May-June timeframe was set for completion of the data collection and comparison efforts, defining the parameters needed, and assembling the required resources," he notes.

In July and August 1996, the data and studies developed by the process action teams will be integrated into a working strategic model for use in developing the operational plan and required force structure. "We've approached our Scientific Advisory Board, Board of Governors, and American Registry of Pathology Board to solicit members who will work with us and our findings," he says. "We want input about how the proposed strategic plan impacts stakeholders' perceptions and expectations." Plans call for this combined group to meet in late August, followed by an internal/external retreat in mid-September.

Michael Annison, president of the Westrend Group and Florabel G. Mullick, MD, SES, Associate Director, AFIP and Director, Center for Advanced Pathology, discuss issues at the May retreat.

The target for a completed strategic plan, including the foundation of an operational plan and required force structure, is October 10, the date of AFIP's next Board of Governors' meeting. "The tested model will go to the Board for approval on that date, and in the weeks that follow we'll make any final course corrections to develop a viable, comprehensive plan," CAPT Wagner says.

"It's an ambitious project for 8 months," he notes, "but that's probably all the time that we have, given all of the proposed changes both in the DoD and in the government as a whole."

HISTONOTES

Helpful Hint: Bouin's solution in the Masson's trichrome stain may be conserved and reused if not heated.

Bouin's solution, used for mordanting, is the initial solution applied in the Masson trichrome staining overnight, or it can be heated in a 56° oven for 1 hour. When slides are placed in the Bouin's solution overnight, that solution may then be retained and reused to treat a batch of slides with the solution heated for 1 hour. Once the solution is heated, it is appropriately discarded as waste. To insure the integrity of the solution, it is recommended that the nonheated solution (if only overnight staining is done) not be used for longer than one week.

USUHS President James A. Zimble, MD, speaks on the future of military medicine at May 23 Ash Lecture

Military medicine—distinctly different from "medicine in the military"—is a unique discipline that must be continued in order to ensure military readiness, according to James A. Zimble, MD, Vice Admiral (Ret), USN, the featured speaker at the Armed Forces Institute of Pathology's Twelfth Annual James Earle Ash Lecture, held on Thursday, May 23, at 8:00 p.m. Dr. Zimble, President of the Uniformed Services University of Health Sciences (USUHS) since 1991, previously served as the 30th Surgeon General of the U.S. Navy. He has been honored by his selection as a USUHS Faculty Senate Packard Lecturer and has received numerous military decorations, including the Defense Distinguished Service Medal and the Navy Distinguished Service Medal.

"Military medicine is not just practicing medicine in the military, and it is not just about casualty care," stated Dr. Zimble. "The discipline needs an official definition, one which will be accepted by all as an absolute requirement, with standards of practice to follow." The shift in the political climate since the end of the Cold War has resulted in downsizing of U.S. military forces, including medical services. Some functions previously performed by military personnel have been relegated to the civilian community. "Of course, it is necessary for the military health services system to downsize," said Dr. Zimble. "We just need to ensure that the downsizing is in balance, and that the residual force has a critical mass of competent military medicine professionals who can readily serve as the first responders to a military contingency. Those who serve in uniform must be competent in the discipline of military medicine."

He believes that the military medical community must achieve cohesiveness in its support of the military medicine specialty. "In the military health services system, we practice medicine in the military, but that is not necessarily 'military medicine,'" Dr. Zimble asserted. "This lack of agreement about exactly what military medicine is—and its uniqueness—is a genuine problem for the entire military medical community." Although working in the trauma ward of a large urban hospital provides useful training, such experience does not adequately prepare a physician to practice combat casualty care, Dr. Zimble contends. In a battlefield setting—a contaminated environment and with limited resources—military medical professionals may have to treat multiple casualties with shrapnel, blast wounds, burns, lacerations, amputations, and severe psychological stress. They must have knowledge of the prevention, diagnosis, and treatment of infectious diseases, with special emphasis on global endemic diseases, and have a solid background in tropical medicine and hygiene and parasitology.

In addition, Dr. Zimble noted, "The military medical professional must be able to work in the joint operations environment, which means being familiar with the organization and lines of communication of sister services." Military medical professionals must be cognizant of logistics characteristics and requirements to ensure that the necessary personnel, equipment, medical material, rations, water, fuel, and means of transport are available when and where needed. "We truly need to preserve the quality triad of health care, education, and research in the military health services system," stated Dr. Zimble. "To do this, we will have to fully explain and justify its unique value in meeting the needs of the Department of Defense." Success in this endeavor, the former Navy Surgeon General believes, will require the continued cooperation and collaboration of the military medical departments of the armed services.

American Registry of Pathology

Study Sets (35MM Transparencies)

Order #	Description	Number in set	Price (US $)	Qty.	Total
SS01	*WHO Histological Typing of Thyroid Tumors. (2nd ed. 1988)	92	$ 60		
SS02	*WHO Histological Typing of Intestinal Tumors. (2nd ed. 1989)	136	$ 75		
SS03	*WHO Histological Typing of Esophageal & Gastric Tumors. (2nd ed. 1990)	120	$65		
SW04	*WHO Histological Typing of Gallbladder & Biliary Tract Tumors. (2nd ed. 1991)	80	$55		
SW05	*WHO Histological Typing of the Salivary Gland Tumors. (2nd ed. 1991)	124	$70		
SW06	*WHO Histological Typing of Upper Respiratory Tract Tumors. (2nd ed. 1991)	200	$125		
SW07	*WHO Histological Typing of Odontogenic Tumors. (2nd ed. 1992)	142	$100		
SW08	*WHO Histological Typing of Liver Tumors. (2nd ed. 1994)	150	$120		
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Ophthalmic Pathology for Ophthalmologists	25–30 August 96	Leavey Conference Ctr, Georgetown University, Washington, DC
Radiation & Chemotherapy Injury: Etiology, Treatment Prognosis & Genetics	7–9 September 96	Sheraton Premiere Hotel, Tysons Corner, VA
5th Annual Pulmonary & Mediastinal Radiology	28–29 September 96	**Menger Hotel, San Antonio, TX**
Morphologic Findings in Renal Diseases & Transplants	1–4 October 96	Holiday Inn, Silver Spring, MD
Endoscopic Biopsies of the Gastrointestinal Tract	5 October 96	Radiologic Path Ed Ctr, Washington, DC
25th Annual Course & Tutorial in Orthopedic Pathology	6–25 October 96	AFIP, Washington, DC
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Basic Forensic Pathology	21–25 October 96	DoubleTree Hotel, Rockville, MD
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Difficult Diagnoses in Surgical Pathology	13–16 November 96	**Charleston Place, Charleston, SC**
Controversias y Adelantos en Patología Quirúrgica	4–7 December 96	**Hotel Presidente Intercontinental Guadalajara, Mexico**
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El curso será presentado en su totalidad en idioma Castellano, siendo de esta manera el primer curso que brindará a todos los colegas de habla hispana los avances más recientes y las técnicas comúnmente empleadas para su diagnóstico. El ofrecer un curso en nuestro idioma natal brinda un forum especial para que los participantes puedan expresar sus experiencias con los tópicos a discutir. Por otro lado los disertantes en este curso son patólogos de habla hispana que practican patolgía académica dentro de los Estados Unidos, y que están en plena capacidad de entender y contestar cualquier inquietud que pueda vislumbrar dentro del contexto de sus conferencias.

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REPRINTS

Primary diffuse large B-cell lymphoma of the breast: a clinicopathologic study of 31 cases

S. L. Abbondanzo, J. D. Seidman, M. Lefkowitz, F. A. Tavassoli, and J. Krishnan

Primary non-Hodgkin's Iymphoma of the breast is a rare neoplasm for which survival data vary among the reported studies. Thirty-one cases of diffuse large B-cell Iymphoma of the breast, which had been seen in consultation from 1973 to 1985 at our institution, were reviewed. This represents the largest number of Iymphomas of this histologic subtype reported to date in the English literature. Histologic examination and immunophenotypic analysis were performed and the results were correlated with clinicopathologic data. The patient population consisted of 29 females and 2 males with a mean patient age of 58.2 years. At the time of diagnosis, 26 patients had unilateral involvement (16 left, 10 right), and 5 had bilateral disease. Mean tumor size was 3.8 cm. Histologically, all cases showed a diffuse large B-cell Iymphoma as classified by the Revised European-American Classification of Lymphoid Neoplasms (R.E.A.L Classification). Immunophenotypic studies on paraffin sections confirmed a B-cell lineage in every case. The majority of patients received chemotherapy and/or radiation therapy. The median survival was 36 months, confirming that this neoplasm has a poor prognosis.

Path Res Pract. 1996;192:37-43.

Solid and papillary epithelial neoplasm of the pancreas: imaging-pathologic correlation in 56 cases

Peter C. Buetow, MD, James L. Buck, MD, Linda Pantongrag-Brown, MD, Katherine G. Beck, MD, Pablo R. Ros, MD, and Carol F. Adair, MD

PURPOSE: To evaluate the clinical, pathologic, and imaging findings of solid and papillary epithelial neoplasm (SPEN) of the pancreas and to correlate imaging and gross pathologic features.
MATERIALS AND METHODS: A retrospective review was performed in 56 patients (53 female and three male patients aged 10-74 years [mean age at diagnosis, 25 years]) with pathologically proved SPEN of the pancreas. All patients underwent computed tomography (n = 49), ultrasonography (n = 31), or magnetic resonance (MR) imaging (n = 9). Tumor size, location, and imaging features were evaluated and correlated with gross pathologic and histologic features.
RESULTS: Mean transverse diameter of these tumors was 9.0 cm (range, 2.5-17.0 cm). They were localized to the tail (n = 30), head (n = 18), and body (n = 8) of the pancreas. All tumors contained some degree of internal hemorrhage or cystic degeneration, and all were well encapsulated. Areas of hemorrhagic degeneration ranged from solid friable tumor to gelatinous or cystic cavities and therefore demonstrated variable imaging features. Calcification was noted in 16 patients. Fluid-debris levels were noted in 10 patients.
CONCLUSION: Imaging studies of SPEN of the pancreas consistently demonstrate variable degrees of hemorrhagic degeneration. Calcification is common. Characteristic fluid-debris levels and signal intensities seen with MR imaging indicate blood products. In the appropriate clinical setting, these findings are useful in making a prospective diagnosis.

Radiology. 1996;199:707-711.

Lipomatous hypertrophy of the atrial septum presenting as a right atrial mass

Allen P. Burke, MD, Silvio Litovsky, MD, and Renu Virmani, MD

Lipomatous hypertrophy of the atrial septum (LHAS) has been associated with cardiac arrhythmias and is defined as fatty infiltration >2 cm thick in the atrial septum. The clinical and histologic features of surgically excised LHAS have not been previously studied. We studied 11 surgical resections of LHAS and compared them with 13 autopsy cases of LHAS and 24 control autopsy hearts. Of 11 surgical patients, eight were women: patients' mean age was 63 years, and six were described as mildly to overtly obese. Symptoms included congestive heart failure, atrial fibrillation, supraventricular tachycardia, palpitations, syncope, and incidental mass found at surgery. Imaging studies typically revealed a right atrial mass with a mean size of 6 cm (range, 2.5-10 cm). Multivacuolated fat was more extensive in surgical ($p = 0.005$) and autopsy ($p = 0.009$) cases of LHAS than in control hearts. Atypical, hypertrophied myocytes were present in 72% of cases of LHAS compared with 8% of controls ($p = 0.0003$). In autopsy hearts, histologically abundant multivacuolated fat, heart weight, and body size were independently associated with increased atrial septal thickness. LHAS can be surgically excised, it has a distinctive histologic appearance marked by the presence of abundant multivacuolated fat and hypertrophied myocytes, and it is associated with increased body and cardiac mass.

Am J Surg Pathol. 1996;20:678-685.

Malignant melanomas in the small intestine: a study of 103 patients

Al M. Elsayed, MD, Major, USAF, MC, FS; Motaz Albahra, MD, LCDR, USN; Ugochukwu C. Nzeako, MD; and Leslie H. Sobin, MD

Objectives: Malignant melanoma shows an unusual predilection to metastasize to the small intestine. A proportion of small bowel melanomas occur without history of an antecedent primary. We evaluated a group of patients with malignant melanoma in the small intestine to further our understanding of this disease. Methods: We reviewed 103 cases of malignant melanoma in the small intestine (77 surgical resections and 26 autopsies) accessioned at the Armed Forces Institute of Pathology between 1945 and 1991 for demographic, chronological, and pathological features. Results: Mean age at time of primary was 45.6 yr for surgical and 34.1 yr for autopsy cases ($p = 0.01$). Mean age at time of small intestinal involvement was 52.2 yr for surgical and 42.7 yr for autopsies ($p = 0.03$). Primary lesions preceded intestinal disease by an average of 5.6 yr for surgical and 2.1 yr for autopsies. The age distribution of surgical patients with and without known primary melanomas at the time of small intestinal melanoma was not significantly different. The same was true for autopsy patients. Using regression analysis, the linear relationship of age at primary melanoma (AAP) on age at small intestinal melanoma (AASI) was given by AAP = 2.30 + 0.85 (AASI), and that of AASI on AAP was given by AASI = 3.94 + 1.02 (AAP) ($r = 0.93$ and $p < 0.0001$ for both regressions). Conclusions: Our data and results support the concept that small bowel involvement by melanoma, even without a known primary, is most probably metastatic. The age at which an unknown primary occurred in cases of intestinal melanoma, or the age at which intestinal metastasis may appear in cases with known primary melanoma, can be estimated. There appear to be two subsets of primary melanoma: one that occurs among younger patients and is more aggressive with rapid metastasis and early death and one that occurs among older patients, is more indolent, and metastasizes less rapidly.

Am J. Gastroenterol. 1996;91:1001-1006.

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